SURGERY.

UNDER THE CHARGE OF

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Diagnosis and Treatment of Spasmodic Stricture of the Œsophagus.—RUSSELL (*British Medical Journal*, June 4, 1898) reports seven cases of this character that have come under his personal observation; he does not believe they are as rare as commonly supposed. This is that stricture which is situated at or near the cardiac orifice of the stomach, and is caused by muscular spasm, superimposed upon a greater or less degree of more permanent contraction.

The apparent rarity of the disease the author believes to be due, in the first place, to the misleading character of the symptoms, suggesting, as they do, disease of the stomach; and, secondly, to the inefficacy of treatment by bougies in this condition, causing a diagnosis of stricture, once made, to be abandoned or modified, since the symptoms persist after supposed dilatation. As to treatment, that which the author has used with success consists in stretching the stricture, by an expanding dilator, to a calibre approaching that of the normal œsophagus at that point. This is not done suddenly at one operation, but with bags of increasing size and at several sittings. Four cases were completely cured by this means, one was much improved, and one was not improved.

The author suggests: That in all cases of persistent vomiting, unless obviously due to disease of the stomach, it should be positively ascertained whether or not a stricture is present; and that it should not be assumed that no stricture or spasm exists because none can be detected by a bougie, nor that stricture is not the cause of the symptoms because these persist after the largest bougie has been passed. In cases of doubt the behavior of food given through a tube may be of assistance. In using instruments for the diagnosis or treatment of stricture it is very easy to be deceived on the question as to whether they have passed into the stomach or not; measurement of the length passed in is no infallible guide. In using the dilator the author always passes it well below the point required, and then withdraws it until it is in the stricture before expanding.

The Surgical Treatment of Pyloric Obstruction.—In treating of the various forms of pyloric obstruction, PAUL (*British Medical Journal*, June 4, 1898) says that of the three operations used in the treatment of fibrous strictures of the pylorus, divulsion, pyloropasty, and gastro-enterostomy, the former is unsatisfactory and must give place to the other two. Pyloroplasty is the best operation, but, unfortunatly, it is not applicable to all cases. When the parts are sufficiently yielding to permit a broad band of healthy mucous membrane to be drawn into the contracted pyloric orifice, the result is perfect—better, he thinks, than is ever obtained by any other stomach operation. When, however, it cannot be done in this manner gastro-enterostomy is distinctly the better operation. Moreover, when active ulceration is present, it is generally undesirable to operate in its immediate neighborhood. Pyloroplasty is probably a less severe operation than gastro-enterostomy, but this need be considered only in exhausted subjects, when pyloroplasty should be done, if possible.

For malignant stricture there are only two operations, pylorectomy and gastro-enterostomy, unless some pyloroplasties for obstruction, where only part of the pylorus was involved, should prove to be successful.

Pylorectomy should be reserved for favorable cases. A gastro-enterostomy is the most that a person in an exhausted condition can be expected to survive. In other cases the extension of the growth places a limitation on the form of operation. Attempts at total excision of the stomach should be very few, and pylorectomy should only be attempted when the growth is very small, and, above all things, freely movable. The preferable form of operation is to unite the cut ends, but where this is impossible they should be closed and a gastro-enterostomy performed. The author has some doubt regarding the choice between simple suture and suture combined with a button or bobbin; he inclines toward the former, when approximation is easy. When there is any difficulty in applying the sutures the posterior ones are in danger of proving insecure, and here the button is an advantage.

Of gastro-enterostomy, the author says its greatest failing has always been a high mortality, due, no doubt, to the exhausted condition of the patient at the time of operation. As a matter of fact, mechanical appliances and simple suture are both very well in their way, and succeed in the right sort of patients, but are not suitable for exhausted subjects. The dangers are increased by their low vitality, and the mechanical support becomes a source of danger. As a foreign body, it lies in contact with the wound, and, in case of the button, about the sixth or seventh day perforation is liable to occur, with extravasation of the gastric and intestinal contents into the peritoneal cavity, and rapid collapse and death. Plain suture has difficulties and dangers quite as great. The time occupied in effecting a water-tight union, the greater danger of contaminating the peritoneum during the operation, and the subsequent tendency which the opening shows to close are substantial objections to this mode of operating. At present the choice lies between rapidity and primary security of the button and the slowness and less perfect primary security of the suture operations. They are neither operations for exhausted subjects. The author proposes the following operation, trusting it may suggest some better if it is not perfect in itself.

"The bowel and stomach having been exposed, a longitudinal incision is made in the former for two inches in the human subject, through the peritoneal and muscular coats only. These are reflected with a small, curved, blunt dissector over an oval area having a diameter of one inch in the centre. The exposed submucosa in then rubbed with a stick of zinc chloride, say half a dozen times, being well dried between each application, when it assumes a gray, dead look. The bowel is now wrapped in a piece of moist absorbent wool and laid on one side, while the stomach is dealt with in an almost similar way. In preparing the stomach for the anastomosis, instead of making a linear incision, an oval patch of musculo-peritoneal coat is excised; the muscular coat being so much thicker in this organ, it is rather in the way if only reflected, and, what is of more importance, the loss of substance helps to prevent subsequent contraction of the opening. Both of the wounds having been duly cauterized, they are brought together, and a continuous suture of the finest green gut or silk is run around the edges, not, of course, penetrating the mucous membrane, but picking up as far as possible the tough submucous coat. Finally, a few Lembert sutures or Halsted sutures are generally desirable, especially in anterior gastro-enterostomy.

The operation has been successful in dogs, a sloughing taking place in forty-eight hours and establishing the anastomosis after good firm union has taken place.

The features of the operation that the author hopes may be reckoned advantages are:

1. The effect is one of pure traumatism. The viscera not being opened, all risk from such sources is avoided.
2. No foreign body is used.
3. The time occupied is less than for a suture operation though more than for Murphy's.
4. The anastomosis resulting from loss of tissue should be more durable than in the majority of methods.

The complete absence of shock in the experimental cases was a noticeable feature as compared with other cases done by other methods. There was much less pain.

The author also briefly reports a series of twenty cases of operation for pyloric obstruction.

The Action of Sympathicotomy on the Exophthalmia and Tachycardia in a Case of Exophthalmic Goitre.—COMBERMALE and GAUDIER (*Gaz. Hebdom de Méd. et de Chir.*, April 24, 1898) report an interesting case in which Jaboulay's operation produced the following results. The patient was a female in whom, for some unknown reason, a goitre began rapidly to increase in size and was accompanied by exophthalmia, tachycardia, and all the symptoms of hyperthyroidization. No medicine appeared to have any effect; the heart could not be calmed, and its increasing action threatened the life of the patient. Recourse was had to section of the cervical sympathetic. The results were: 1. An immediate diminution in the exophthalmia. 2. A decrease of the pulse during a week from 200 to 100 per minute, and at the same time the disappearance of præcordial pain. 3. Absence of any modification in the goitre itself.

The cessation of palpitation, the lessened dyspnœa and disappearance of angina caused sufficient relief to make the patient satisfied with the operation, while the disappearance of the tachycardia and of the other dangerously threatening symptoms recompensed the operators.

The sudden drop in the pulse the authors would ascribe not to any direct